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Traumatic landscapes: Two geographies of addiction

Jesse Proudfoot

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Author: Jesse Proudfoot

Affiliation: Durham University

Address:
Jesse Proudfoot
Department of Geography
Durham University
South Road, Lower Mountjoy
Durham DH1 3LE
United Kingdom

Phone: +44 (0)7958 626 638

Email: jesse.proudfoot@durham.ac.uk

Abstract

The confluence of the contemporary opioid crisis and the fallout from the Great Recession has renewed interest in theories of addiction that can account for the relationship between individual symptoms and large-scale socio-political forces. Gesler's (1992) theory of 'therapeutic landscapes,' examines the ways that social, political, and cultural forces, embedded in place, contribute to health and wellbeing. This article considers the inverse of the therapeutic landscape: the *traumatic* landscape that harms its inhabitants, proposing it as one way of understanding how addiction is related to place. I draw on research in health geography, medical anthropology, and critical psychology to develop a novel theorization of the relationship between place, trauma, and addiction. Drawing on eighteen months of ethnographic fieldwork with drug users exiting the prison system in Chicago, Illinois, the article considers the life histories of two men whose addictions to drugs and alcohol are profoundly related to place. Through close readings of these cases, I develop two readings of *addiction-in-place*, one in which addiction is the result of environmental stresses that produce a need to use drugs as a form of self-medication, and another in which the landscape acts as a container for histories of trauma and produces an addiction resembling an psychoanalytic symptom, expressed in self-destructive acts. Finally, through my use of the case history method, I contribute to methodological debates about how to research experiences of place and health, arguing that close attention to lived experience is necessary to draw links between macro-level arguments about the stresses produced by structural violence and the subjective experience of trauma that lies at the heart of addiction.

Keywords: United States; drug addiction; therapeutic landscapes; health geography; trauma; case history method; psychoanalysis.

Introduction

The confluence of the contemporary opioid crisis and the fallout from the Great Recession has renewed interest in theories of addiction that can account for the relationship between individual symptoms and large-scale socio-political forces (Case and Deaton, 2015; Lopez, 2018; Siegel, 2018). This relationship between health, illness and social (specifically, socio-*spatial)* relations has, of course, been a perennial subject of health geography. One of the best-known examples is Gesler's (1992) concept of *therapeutic landscapes*, proposed in this journal over 25 years ago to describe cultural landscapes that promote "physical, mental and spiritual healing" (1993: 171). Drawing on the insights of the 'new' cultural geography (Cosgrove and Jackson, 1987), Gesler argued that such places should be understood not simply as physical locations but as "symbolic landscapes" imbued with a "sense of place" that make them sites of healing (Gesler, 1992: 735).

Yet the metaphor of the therapeutic landscape—perhaps because it began as a response to medical geography's tendency to focus on the negative effects of place—always seemed to be haunted by its opposite: the landscape that does not heal, but harms. Indeed, the landscapes that Gesler cited to explicate his new concept were just such places: Tuan's "landscapes of fear" (1979), Dear and Wolch's "landscapes of despair" (1987), and Walter's "sick places" (1988). In her review of the first edited volume on therapeutic landscapes, Kathi Wilson enjoined geographers to remember such places, insisting that "while the healing properties of places are important, so too are the negative health effects associated with particular places" (2001, 347).

The therapeutic landscape, however, was never intended to function as the antonym of every geographically-specific form of ill-health, from environmental pollutants to food deserts. What therapeutic landscapes offer, rather, is a metaphor for thinking about the relationship between health and place through the lenses of meaning, social relations, and political economy. The antonym of the therapeutic landscape therefore is not simply the unhealthy place, but the

traumatic landscape: the place that harms people not only through physical dangers, but social dislocation, precarity, and hopelessness.

In this article, I consider the relationship between place and trauma by looking at a public health issue that many have argued is a result of people's attempts to manage trauma: drug and alcohol addiction. My argument is that places can indeed be traumatic and that these traumas can lead to addiction. This means that we can think about some places as *addictogenic*: landscapes that are productive of addiction. However, the ways in which landscapes can be traumatic are complex, and understanding the relationship between place, trauma, and addiction requires methods that explicate how these threads come together in individual drug users' lives. This article, then, proposes a theory of traumatic landscapes and a methodological framework for examining them, anchored by extended readings of two cases which, I argue, point toward two different illustrations of how trauma and addiction can be embedded in place.

I begin by situating my argument within the literature in health geography that develops a social and political theorization of the relationship between health and place. I then turn to research in medical anthropology that has proposed similarly social models of addiction, arguing that addiction is the result of a variety of oppressions, from racism and colonialism to suffering under neoliberal capitalism. I compare these theories to a series of arguments in critical psychology, which argue that addiction is the product of environmental stresses and social dislocation. I argue that understanding the relationship between place, trauma, and addiction requires a methodology of close listening to, and reading of, individuals' stories in order to understand how large-scale socio-political processes manifest themselves in the singular experience of an addiction. Drawing on the cases of two men struggling with their substance use, I present two histories of *addictions-in-place*. The first illustrates an addiction that is the product of environmental stresses, which generates a need to use drugs to manage overwhelming affects. The second shows how *past* traumas can produce an addiction connected in complex,

unconscious ways to the places where they occurred. Each of these cases captures a different aspect of compulsive drug use in relation to place: the first where the place itself appears to be the source of trauma and the second where trauma and place are connected through the unconscious. The first is a clear example of addiction's socio-political etiology, where problematic drug use appears to be a direct result of structural violence, while the second illustrates a less obviously political, yet still thoroughly relational, account of addiction. I propose two different ways of understanding the addictions that result from such landscapes: the first conforming to the 'self-medication' model of addiction, and the second illustrating the less commonly discussed self-destructive, or masochistic dimensions of addiction, which results from repressed traumas returning in the form of a psychoanalytic symptom. I conclude by considering what these ideas might mean for approaches to addictions treatment and social justice for drug users.

Addiction, place, and social suffering

The geographic metaphor of 'therapeutic landscapes' has spawned a substantial literature theorizing the relationship between place and wellness, examining not only traditional sites of healing, such as spas and religious pilgrimages (Gesler, 1993, 1996), but everyday spaces, including beaches and gyms (Andrews et al. 2005; Collins and Kearns, 2007), and healthcare facilities (Wilton and DeVerteuil, 2006; Evans et al., 2009; Gesler and Curtis, 2007; for reviews see Bell et al. 2018, Williams, 1999, 2007). Over time, geographers have expanded upon the concept, examining spaces that were less than clearly therapeutic, including "unhealthy places" such as rust-belt towns, in which geographies of class inequality produce differential health outcomes (Wakefield and McMullen, 2005); places with ambiguous relationships to health, such as gay bathhouses, where potentially risky sexual practices coexist with spaces of supportive community (Andrews and Holmes, 2007); as well as using the concept to explore profoundly

anti-therapeutic landscapes such as the Gulags of the former Soviet Union (DeVerteuil and Andrews, 2007).

Increasingly, geographers have insisted that therapeutic landscapes should be understood as relational spaces, emphasizing how such landscapes "emerge through a complex set of transactions between a person and their broader socio-environmental setting" (Conradson, 2005: 338). This relationality considers health and health outcomes not as properties of individuals or statically-bounded spaces but as products of a dynamic relationship between bodies, pathogens, social relations, systems of meaning, and the natural and built environments (Cummins et. al. 2007; Curtis, 2004; Duff, 2012; Massey, 2005).

The definitions of addiction that dominate the field of addictions medicine provide an example of the sort of individualizing, biomedical approaches challenged by relational understandings of health and place. The US National Institute for Drug Abuse defines addiction as a "chronic, relapsing brain disease characterized by compulsive use of drugs or alcohol" (NIDA, 2016: 1), while the American Psychiatric Association describes the "cognitive, behavioral, and physiological symptoms" and "underlying changes in brain circuits" apparent in individuals diagnosed with "substance use disorder" (APA, 2013: 481). Alongside these biomedical models, the twelve-step recovery literature of Alcoholics and Narcotics Anonymous takes up the 'disease model' of addiction in its own way, viewing the drug or alcohol user as a person suffering from a "disease of the will" (Valverde, 1998). Each of these models shares a view of addiction as an individual pathology, whether one of 'hijacked' dopamine circuitry in the brain, pathological behaviors, or spiritual malady.

Against these individualizing, biomedical understandings, social scientists have argued for a social model of addiction—one that accounts for the obvious importance of social and environmental factors in the production and experience of addiction. Researchers have shown

how addictions disproportionately harm people who are socially marginalized because of their race, class, and gender (Bourgois et al. 2006; Baer et al. 2003; Netherland and Hansen, 2016; Raikhel and Garriott, 2013); they have demonstrated how the risks associated with drug use are less a product of substances themselves than "the social situations, structures, and places in which risk is produced" (Rhodes et al. 2005: 1027); and they argue that addictions can be understood as the product of structural forces such as neoliberal capitalism, racism, and colonialism (Alexander, 2010; Bourgois, 1995; Garcia, 2010).

As Baer et al. argue, self-destructive drug use by marginalized people should be understood as a form of "self-medication for the psychosocial injuries of oppression": an attempt by the marginalized "to cope with the hidden and overt injuries… of poverty, discrimination, social ostracism, toxic living and working conditions, [and] breakdowns in community social life" (2003: 225). In such cases, addiction constitutes what Singer and Toledo (1995) call an "oppression illness", a psychic and somatic response to the "chronic, traumatic effects" of oppression "and the internalization of these social factors in individuals" (quoted in Baer et al., 2003: 213, 225). Kleinman, Lock, and Das (1997) refer to this as "social suffering", a concept that calls attention to the social production of even the most intimate forms of trauma and to its spatiality, including "the toxic and predatory environments of urban slums… [where] depression, suicide, violence, PTSD, and substance abuse cluster together" (Kleinman, 2012: 118). In other landscapes, such as New Mexico's Española Valley—site of the highest per capita rate of heroin-related deaths in the United States—Angela Garcia argues that intergenerational heroin addiction must be understood in relation to the "material and cultural losses that resulted from the region's embattled past" (2010: 10), including its four centuries of colonial dispossession. Such sites of loss and violence, like the slums invoked by Kleinman, are places where trauma is written into the psychical and material landscape—"wounded" places in Karen Till's (2012) words, from which addictions seem to spring as a means of coping with suffering.

Another reading of how to situate addiction in place is presented by the recent spate of bestselling books on addiction and drug policy, including *Unbroken Brain* (2016) by Maia Szalavitz and Gabor Maté's (2009) *In the Realm of Hungry Ghosts* (see too Alexander, 2010; Hari, 2015; Hart, 2013; Lewis, 2015; Lupick, 2017). Notwithstanding important differences between them, these authors all repeat a now-familiar critique of mainstream biomedical approaches to addiction, arguing that addiction should be understood as an adaptive behaviour that emerges in response to stress and trauma (Peele, 1985).

Two studies are so central to this critique that they appear in every iteration: Lee Robins' psychiatric epidemiology of opiate-addicted soldiers returning from Vietnam (Robins et al. 1974, 1975) and Bruce Alexander's "rat park" experiments on morphine dependence in rats (Alexander et al. 1978, 1985). The Robins study demonstrated that despite extraordinarily high rates of heroin use among soldiers in Vietnam (43% used opiates and 21% met the criteria for addiction), fully 95% of those who became addicted while abroad stopped using opiates without significant difficulty upon their return to the United States (Robins et al. 1975: 958). This remarkable remission rate suggests that context, or *place*, plays a crucial role in addictions, with stressful situations, such as war, producing an environment in which 'addictions' flourish. Conversely, once removed from this addictogenic environment and returned to familiar social ties, these same men simply stopped using drugs. As the journalist Dan Baum notes wryly: "Take a man out of a pestilential jungle where people he can't see are trying to kill him for reasons he doesn't understand, and—surprise!—his need to shoot smack goes away" (1996: 62).

Meanwhile, Bruce Alexander's "rat park" experiments demonstrated that environmental stresses were a crucial aspect of drug taking not only in humans but also in animals. Animal studies of addiction purported to show that when given access to drugs such as cocaine and heroin, laboratory rats would self-administer large amounts and become addicted (Woods, 1978 cited in Alexander, 2010). Alexander and colleagues posited, however, that these studies were flawed in

that they all involved isolating rats in cages, depriving them of a "normal social life, environmental richness, and mobility" (Alexander et al. 1985: 79). The researchers developed an "enriched environment" called "Rat Park", including ample space and many other rats, and discovered that the inhabitants of Rat Park generally shunned the drugs, consuming nearly 20 times less morphine than those in isolation and failing to become addicted (Alexander, 2010: 193-195).

Taken together, the Rat Park experiments and Robins' study of opiate use in Vietnam make a powerful argument for the importance of the "setting" (Zinberg, 1984) in drug addictions. Ethnographic research with drug users, meanwhile, demonstrates how structural violence can produce mental health problems such as addiction. Each of these literatures contributes something crucial to the argument that *place matters* in addiction: first, by demonstrating how places can produce stress and trauma that can lead to self-medication through drugs, and secondly, by showing how experiences of trauma can be rooted in place and can lead to addictions. In the sections that follow, I present two cases from my research with recovering drug users that illustrate these two different relationships between addiction and place: the addictogenic environment and landscapes of trauma.

Methods

This research is based on ethnographic fieldwork conducted in Chicago, Illinois, at a halfway house for men with substance abuse problems. The research took place over a period of 18 months in 2012-2013, during which time I took part in daily life at the halfway house, attended recovery meetings, and conducted weekly life-history interviews with 21 men, 16 of whom continued beyond the first interview. Of these 16, I conducted between two and 19 interviews with each participant, with an average of seven interviews each. Interviews were conducted in a private room at the halfway house and ranged from 45 minutes to 90 minutes in length.

Interviews were recorded and later transcribed. The interviews were unstructured and interviewee-led, allowing the participant to direct the discussion towards whatever they felt was most significant to understanding their life and drug use. Participants were informed that interviews would be anonymized and significant details from their lives have been changed to protect their identities.

While the themes that I explore in this article were present in interviews with many of the participants, this article focuses on material from two in particular. Focusing on only two participants and presenting them as case histories affords me the opportunity to examine them in the detail required to make arguments about how large-scale socio-political processes manifest themselves in the ultimately singular experience of an addiction. This approach draws on the tradition of the psychoanalytic case history, a "style of reasoning" (Hacking, 1990: 7) that John Forrester (2017) distinguishes from the statistical reasoning prevalent in experimental psychology. For Forrester, the case history is a form of "reasoning from shared examples" (52) in which particular cases are used as reference points that orient fields of knowledge, as in law, and as pedagogical tools, as in medicine. Here, I follow Forrester's framing of the case history as an "exemplar" (Kuhn, 1977, in Forrester, 2017: 7)—a "shared example" through which one examines an issue or theory—and present these case histories as two distinct ways of theorizing the relationship between addiction, place, and trauma.

'C': The addictogenic environment

The first case history that I present provides an illustration of the *addictogenic* environment: a place that produces traumas from which addictions may result. The addictions that such place produce can be understood through Edward Khantzian's theory of 'self-medication', in which people use substances "adaptively" to "cope with unbearable… feelings and/or adapt to external realities that are otherwise unmanageable" (2003: 8).

The place that I am concerned with is Chicago's West Side, including the neighborhoods of North Lawndale, West Garfield Park, and Austin—areas which have long been marked by precarity, violence, and structural racism. These once middle-class Jewish neighborhoods were a key site for racist housing practices such as redlining and blockbusting during the mid-century, after which the area was subsequently "economically devastated by successive waves of deindustrialization, divestment, and decentralization" (Peck and Theodore, 2008: 255; see too Coates, 2014; Hirsch, 1998: 31-33, 193-194). Today, the 95% African American neighborhood has an official unemployment rate of 30% for Black men, 70% of whom have criminal records, and the neighborhood ranks consistently at the top of violent crime indexes for the city (CPD, 2018; Eltagouri, 2017; Street, 2002).

'C' is an African American man who grew up in the West Side in the 1980s and 90s. He was 28 years old when we spoke in 2012-2013. We conducted 13 interviews over a period of five months while he was a resident at the halfway house. C had been released from prison two months earlier, following his fifth sentence for distributing narcotics.

C was an only child from a stable family, raised by his mother, father, and grandmother, who worked creatively with limited resources to provide him with a safe upbringing. C's father died when he was 11 years old, followed by the death of a grandfather the following year. These tragedies affected him profoundly. He lost interest in school and joined a gang, began selling drugs, shoplifting, and using drugs, including marijuana, PCP and ecstasy. At the same time, C was no simple portrait of a troubled youth on the school-to-prison pipeline: after a period of truancy, mourning his lost relatives, his grandfather persuaded him to return to high school and he resumed playing basketball with the school team, eventually winning a major championship.

C 'caught' his first adult case for possession of drugs at 17, and, after violating the terms of his probation, eventually served six months in prison. After his release, C's girlfriend became

pregnant and his first daughter was born later that year. He dropped out of school and returned to selling drugs, now with the motivation of providing for his new family. After being arrested again and serving a brief period of incarceration for possession, he made a number of attempts to find legal work and get his GED, but, in a neighbourhood plagued by structural unemployment, he continued to find himself returning to the streets.

As the years passed and his family grew to five children, the demands of providing for his family increased. C continued to make attempts to exit "the lifestyle" of selling drugs, but a combination of economic necessity, entrenched neighborhood connections, and boredom drew him back to it, resulting in further prison sentences. The stresses of the lifestyle also became more pronounced as C continued to lose friends and family to violent deaths. Increasingly, he felt the need to use drugs to cope with selling drugs:

> "I got to worry about the police, worry about people stickin' me up, worrying about the mob that I'm involved with… gon' be in a war with this other mob. Worryin' about me getting killed or me killin' somebody, or losin' one of my friends, or one of my friends killin' somebody. You know?"

It was these quite material threats that C repeatedly associated with his drug use:

> "those types of things, right there, that's what—that's what drives people to gettin' high. You feel me? Because you're nervous… you've got the jitters, you're steady lookin' over your shoulder. So it was like… you gon' smoke something that calm you down… so you won't be steady movin' around."

C draws an explicit connection in this quote between his drug use and his life on the street. He presents his drug use as an attempt to manage the effects associated with dangerous work, both in the sense of self-medicating against anxiety ("because you're nervous") and as a practical means of appearing in control ("so you won't be steady movin' around").

C's drug use at other times appeared to be similarly connected to the pressures of life on the West Side. Describing his "habits," including cigarettes, alcohol, marijuana, and PCP, one could not help but be struck by the dangerous, precarious, and seemingly hopeless circumstances in which they occurred. Threats of danger haunted his time at home:

> "you paranoid all day, you always lookin' over your shoulder. I got to worry about… people not breakin' in my house tryin' to steal my stuff, because they think I'm gettin' money."

He describes his living situation before his last incarceration:

> "We was havin' some rough times before I caught this case and ended up getting put out of our apartment. We had nowhere to stay. …we had three kids at the time… My oldest daughter's mother, she has my daughter and… three other kids… and she had got put out of her apartment as well… So we all ended up stayin' in a hotel… I had to pay for the rooms, pay for the food…"

And he describes his general sense of frustration at doors being shut in his face as he tried again and again to find meaningful work away from the streets:

> "I had a lot of angry feelings… I wanted to do better, but I just couldn't find the right path or the right track. You know? …I knew what I wanted to do, I just couldn't seem to find… the door to grab to open it."

If this is an addiction, it is clearly one that emerges in response to an addictogenic environment, where threats of physical danger and near-constant stress are intermingled with feelings of hopelessness at finding a way out. Indeed, one of the most notable things about interviewing C was how little he appeared to have a problem with drugs themselves, especially compared to many others in the halfway house, whose whole lives had been given over to the pursuit of

drugs. When C described the problems that plagued him, they always seemed to centre on the stresses of *selling* drugs, and only secondarily on using them. In the halfway house, far from the streets and the lifestyle, he appeared entirely self-possessed.

While addiction is commonly described as an experience of "impaired control" over one's substance use—as it is in the DSM-V (APA, 2013: 483)—C's drug use appears far more like the definition of addiction as *a behavior that serves a psychological purpose* (Peele, 1985; Pickard 2016)—an adaptive behaviour that allows him to manage the affects associated with living in a traumatic environment. If the notion of "impaired control" means anything here, it describes C's *material* circumstances: his inability to extricate himself from an impossible situation, or to provide for himself and his family without risking death or imprisonment.

Nevertheless, C understood himself as a person with a drug problem. During his last incarceration, C was sent to a prison with a mandatory substance abuse treatment programme, where he spent almost two years attending drug and alcohol counselling sessions based in twelve-step recovery philosophy. Though he initially attended the program simply in hopes of receiving more lenient probation, it was a formative experience for him:

> "I didn't think I had a problem. You know? I didn't think it was addiction… until I went to [the programme]. That's when I… ended up finding out that I had a problem."

The language of 'recovery' and the twelve steps provided C with a way of making sense of aspects of his life that had previously remained opaque to him. Step One of the twelve steps ("we admitted that we were powerless over our addiction, that our lives had become unmanageable") was particularly meaningful to him. As he put it, "I ended up finding out… that I was powerless over a lot of things that was goin' on around me". What was striking about C's appropriation of twelve-step discourse was the way he applied its insights not simply to drugs but to other aspects of his life as well. Immediately after explaining his discovery of his

powerlessness, he recounted the recent deaths of six friends and family members—implicitly associating these tragedies with his experience of powerlessness. Hearing this theme of powerlessness recur over a number of interviews, I asked him whether powerlessness applied more to his drug use or to his life on the streets:

> "I'm powerless over everything that goes on around me… Everything that you doin' on that side [i.e. drug dealing] is unmanageable. And you have no power over anything that goes on… 'Cause if you had power over anything that you was doin', then nine times out of ten, you probably wouldn't even be doin' that!"

We can see here why twelve-step discourse resonates powerfully for an African American ex-offender living in one of the most violent and economically depressed neighborhoods of the United States. As Philippe Bourgois puts it, "substance abuse in the inner city is merely a symptom—and a vivid symbol—of deeper dynamics of social marginalization and alienation" (1995: 2). C's 'addiction' can be understood as a product of an addictogenic environment: it is a symptom of structural violence, which generates a need to self-medicate in the face of impossible circumstances.

'E': Landscapes of trauma

While C presents us with an example of addiction that appears to be the direct result of a traumatic environment, my second case demonstrates how histories of trauma can be written into the landscape, provoking episodes of compulsive drug use even when no obvious traumas are evident. In part because these traumas belong to the past, they can give rise to different forms of addiction—in this case looking less like a conscious attempt to self-medicate and more like self-destructive, or masochistic, acts. Such addictions suggest, I argue, that a trauma which occurred in the past has been repressed and returns in the form a symptom mediated by the unconscious (Fink, 2013). Drawing on work by psychoanalytic geographers, I consider how such

unconscious dynamics can be rooted in place, and how addicted subjectivities can be routed through landscapes of trauma (Blum and Secor, 2011; Kingsbury and Pile, 2014; Kingsbury, 2007).

'E' is a 54 year old white man from the North Side of Chicago. He had recently been released from an eight year sentence for burglary and he had spent 30 years of his life in prison at that point, nearly all of it for burglaries related to his drug use. I interviewed E seven times over a period of four months before he was kicked out of the halfway house for violating his parole, using drugs, and getting into a fight with a fellow resident.

The North Side neighborhoods where E grew up were far less violent and better resourced than C's West Side. When E came of age in the 1960s and 70s, the North Side had weathered the mid-century urban woes of suburbanization, 'blight', and struggles over public housing that were typical of Chicago yet had remained stable and comparatively prosperous (Hirsch, 1998; Seligman, 2004).

While E's neighborhood was more stable than C's, his family life was considerably less so. His father left abruptly when E was four years old and his mother and new stepfather were abusive alcoholics who regularly beat him and his younger brother, while sparing the stepfather's own children. In his early teen years, he was drugged and sexually assaulted by the father of a friend. He remembers little of the experience but vividly recalls his friend begging him not to leave him alone, since he was also being sexually assaulted by his father during this period. Around the same time, E began drinking, using marijuana and LSD, and regularly injecting PCP.

E began shoplifting and burglarizing businesses in his teen years, eventually being arrested and serving time in a juvenile detention centre for stealing a car. He left his parents' house upon his release, feeling that he had been abandoned by them when he was incarcerated. For the rest of his life, E cycled in and out of prison, as he described it: trying to do right, then getting drunk

and high (later often on cocaine), committing a burglary, and getting locked up again. In prison, he witnessed truly horrifying violence including stabbings, beatings, and murders, suffered numerous assaults himself, and spent extended periods in solitary confinement.

E's life has clearly been marked by profound trauma, and his use of drugs and alcohol is related to it. As I have argued though, his addiction appeared very different from C's. While C's use of drugs appeared to be an attempt to manage the effects associated with stresses in the present, E's seemed to be tied in a more complicated way to the events of his past and to the place where he grew up.

Over the course of our interviews, E experienced two 'relapses' in the language of twelve-step recovery. Crucially, both of these events occurred during visits to "the old neighborhood". In the interviews preceding his first relapse, E was deeply anxious and insisted that he was not getting the help he needed, repeatedly asking staff if they would check him into a hospital. On the morning of the relapse, he later described how his anxiety had dissipated and been replaced by a feeling of intense energy as he went to visit his old neighborhood. He recalled his actions unfolding as if "on remote control" as he stepped off the train. He bought a half pint of Southern Comfort whiskey and drank it while walking around the neighborhood, feeling good and greeting people as he walked. He bought another and went to a bar he used to frequent, looking for "people that would know me", and—not finding any—continued drinking until he blacked out, regaining consciousness hours later with a broken hand and fragmented memories of getting into a fight, snorting cocaine, and threatening to cut off his parole-mandated ankle monitor.

The second relapse occurred approximately one month later. After returning to the old neighborhood to buy Christmas presents for his family, E ran into people he described as "old friends" who invited him to a bar for a birthday party. A series of bizarre events unfolded,

centering on E's discovery that the man whose birthday was being celebrated had fallen into a diabetic coma. Thinking he was dead, he pleaded for help from the other guests and, when no one took his demands for help seriously, got angry, began drinking, and was ejected from the bar for threatening the bartender. Upon returning to the halfway house he got into further altercation with a staff member and upended a table when he felt that no one would listen to his account of what had happened—though crucially, when given the opportunity, he was seemingly unable to speak.

As I have noted, both of these events occurred when E returned to visit the 'old neighborhood'. While it is commonly acknowledged in twelve-step discourse that returning to the place where one's drug use was centered is often a 'trigger'—wisdom that is encapsulated in the injunction to avoid certain "people, places, and things"—it is nevertheless worth examining how, precisely, E's drug use is related to the neighborhood and how we can best make sense of his 'addiction'.

The first thing one notices about E's relapses is that they look like *acts* directed at the people around him—acts which attempt to communicate something about his emotional state. In the weeks leading up to his first relapse, E repeatedly emphasized his mounting anxiety and his feeling that he needed more help than staff were providing. His anxiety was heightened by his sense that his concerns were not being taken seriously—a concern that was echoed during his second relapse when his pleas for assistance with the comatose man were ignored. Later, when E found himself in trouble with staff following his second relapse—despite having reasonable explanations which could have resolved the situation—he simply refused to speak, as if reenacting the experience of not being heard. In psychoanalytic terms, we could understand these acts as a *repetition* that occurs in place of the *remembering* of a traumatic event or prior relationship (Freud 1914). I argue that E's relapses look very much like *demands* that are addressed to the other (Fink, 1995: 89), they are acts that are intended to communicate something to the staff of the halfway house and, presumably, to me as well.

One indication that there may be unconscious dimensions of E's relapses that are worth attending to comes from his description of the morning of the first relapse. After weeks of anxiety, E described waking up on the morning of his relapse "in a good mood… it was like a *renewed energy*". This energy built until it "came to a peak" when he stepped off the train in the old neighborhood and found himself entering a liquor store "on remote control". This transformation of anxiety into a feeling of pleasurable exhilaration evokes Lance Dodes' (2014) remarks on the psychology of drug craving and addiction. In his critique of pharmacological models of drug craving, Dodes notes that users often report feeling relief from cravings not when they ingest drugs but earlier, when they *make the decision* to use them. Dodes argues that this happens because addiction is a psychological response to the sense of "overwhelming helplessness" (91) experienced by the user, and choosing to ingest a substance is an attempt to exercise agency in the face of this helplessness. For this reason, users feel relief as soon as they make up their minds to do something, not once they physically ingest their drug of choice. In a similar sense, I think that E's anxiety fades away because, at some level, he had decided to relapse. He did so not because he desperately craved alcohol (he had not had a drink in five years at that point) but because, unconsciously, he believed that this act would communicate his desperation to the people who were ignoring him. Indeed, when E recounted the story of his relapse to me the following week, he described it as being "exactly what I thought would happen… I kept complaining [that] something's gonna happen… [and now] they can see that I was right".

As I have already noted, there is also a distinctive geography to E's relapses: both occur when he returns to the old neighborhood. Why is this? Part of the answer is clearly that the neighborhood is intimately connected with E's family—both in the sense that his trips involved visiting family and buying Christmas presents for them, and because visiting the neighbourhood confronts him with the ambivalent feelings he holds for his traumatic upbringing there. In describing his

relapses to me, however, the dominant theme that E articulated was a broader concern with recognition and loss. In both cases, E's returns to the neighborhood refer explicitly to attempts to find people who recognize him—attempts which are frustrated. In the first relapse, after walking around "greeting everybody… that I ran into" he finds himself unwittingly walking in the "total opposite" direction he "should've been… for some reason," ending up at "a bar I used to go in… and there was people that… *either would know me, or knew of me*". In the second relapse, he similarly recounts being invited into a neighborhood bar by people whom he first describes "old friends" only to later describe them as people who "kinda knew me" and finally, when no one helps him with the comatose man, to declare "I don't know these people". The ambiguity over whether people recognize him that pervades E's accounts is striking, evoking a sense of loss and alienation as he searches for something in his old haunts that would connect him to the neighborhood of his youth. The social ties that once provided an identity prove difficult to locate and the now-gentrifying neighborhood looks different from his memories, as he remarks of the first bar he visits, "it used to be, like, a Country & Western bar… During the day, it's [still] all the regulars, and then at night, [a] more, like, yuppie crowd comes in". As Angela Garcia observes in the context of dispossessed Hispano heroin users in New Mexico, drug addictions often concern "mourning a sense of place" (2010: 7). As E's working-class North Side neighborhood has progressively gentrified during his long periods of incarceration, he finds it increasingly difficult to locate himself there and be recognized, finding at best "people who knew *of* me" and "people who knew my friends". This mourning of a sense of place is central to E's relapses, I argue. His returns to the old neighborhood are—in addition to being a confrontation with traumas from his past—attempts to reconnect with this past and reaffirm his identity in relation to a place. His failure to find what he is looking for there is key to his return to self-destructive drinking and drug use.

This masochistic dimension of E's drug use distinguishes it from the 'self-medication' I have used to describe C's response to the addictogenic environment. Rather than simply being used as a strategy for managing distressing effects, drugs are also used in complex ways in response to unconscious conflicts, for example, to facilitate self-destructive acting-out. As psychoanalysts argue, masochistic acts may serve to "manage sadistic and destructive aggression" by projecting it onto an object like a drug, which can then be consumed and incorporated into fantasies of both omnipotence and self-destruction (Palacios-Boix and Laliberté, 2018: 69), or they may externalize a chaotic inner state in an attempt to communicate something to others. As Palacios-Boix and Laliberté write, such drug users appear to be "seeking to produce a chaotically destructive state in their lives, rather than pleasure" (63; see too Glover, 1932; Wurmser, 1974, cited in Palacios-Boix and Laliberté, 2018).

E's case invites a consideration of the unconscious because there is no obvious cause in the environment. The relapses appeared out of nowhere—or more precisely, from the *where* of the neighborhood itself. As E recounted when he described the first episode: "I stepped off the train … and everything changed… it's hard to even explain". Inexplicable moments like this are worth attending to because they suggest the presence of other factors at work, including traumas that belong not to a place in the present but to the subject's history there (Blum and Secor, 2011; Coddington and Micieli-Voutsinas, 2017). I argue that E's relapses are prompted by his returns to the old neighborhood not because of environmental stresses in the present but because the place connects him in complex ways to traumas in his past. As Duff argues, many therapeutic landscapes "may have little or no *innately* therapeutic value at all" drawing whatever benefits they confer relationally, from the "social" and "affective resources" that subjects derive from them (2012: 1394). Likewise, a relational understanding of *traumatic* landscapes assumes that even in the absence of obviously traumatic conditions, people may experience places as traumatic because of the complex—and sometimes unconscious—subjective histories that they evoke. E's

relapses can be understood as events that render visible his fraught history in this place: they are eruptions that, in Trigg's words, evince "the tension between the experience of place in the present and the blocked emergence of a traumatic memory rooted in the past" (2009: 89).

Conclusion

Writing in the midst of the ongoing opioid epidemic—a crisis with clear social, political, and geographical dimensions—there is a heightened need to examine how addictions are related to large-scale socio-political forces and how they should best be treated. Drawing on the metaphor of therapeutic landscapes as a way of understanding the interrelation of social relations, politics, place, and health, I have attempted to contribute to these efforts, arguing that in order to understand how forms of structural violence such as racism and inequality produce addictions, we must listen carefully to the experiences of drug users. Through a methodology of close reading of case histories, we are able to examine the ways that large-scale social phenomena find expression in the singular experience of an addiction. Through two such readings, I have proposed two distinct ways in which addictions can be related to landscapes: the addictogenic environment, where the landscape produces traumas that give rise to a need to self-medicate, and landscapes of trauma, where place acts as a container for traumas, reconnecting subjects to traumatic histories and producing an addiction routed through the unconscious.

Let me conclude by briefly considering how these two readings of addiction might inform approaches to treatment and questions of social justice for drug users. C's case seems to illustrate perfectly an addiction with a socio-political aetiology. C's drug use is a clear attempt to self-medicate against the stresses of living in a violent and structurally disadvantaged neighbourhood. As I have argued, when we examine C's drug use in this way, there is little about it that could be called *substance* addiction in any conventional sense: the compulsions he struggled with were centred far more on the material problems of the neighborhood—economic precarity, violence,

and hopelessness—than anything to do with drugs themselves. Speaking with C in the halfway house, where he was temporarily separated from the stresses of the neighborhood, it was easy to be reminded of Lee Robins' heroin-addicted Vietnam veterans and to imagine that his 'addiction' might simply disappear if his war ended.

By comparison, E's addiction looked like one that followed him wherever he went. Even though his relapses were clearly tied to his visits to the old neighborhood, the anxiety he was plagued by in the halfway house—to say nothing of his many previous relapses—spoke to a relationship with drugs and alcohol that went well beyond the management of affects produced by a stressful environment. E's addiction referred to repressed traumas from the past, and the symptom that he developed to deal with them manifested itself in outbursts of self-destructive behaviour. As E himself put it, "it wasn't the drinking, or anything like that, it was just totally self-destructive". His real addiction, he mused ruefully, was simply to "that self-destructive thing".

One thing that these cases suggest then, is that analyzing addiction as a socio-spatial phenomenon might encourage us to approach the treatment of substance abuse *relationally*, focusing less on drug use itself and more on the forces that produce harmful use. My argument here is not simply to advocate harm reduction, essential though this is. My point is that C and E's 'addictions' both demonstrate how addiction is often a *reification* of trauma, in which histories of trauma and present-day stresses produce a symptom that people depend on to manage them. Approaches to treatment that focus solely on a person's substance use then, run the risk of mystifying the traumas that have produced it.

Addressing the traumas that give rise to addiction, however, will look quite different depending on the nature of these traumas. Here again, the two readings that I have provided offer guidance. For addictions like C's, the question of addressing trauma means something quite material. The levels of violence and the sheer inescapability of poverty in communities like his means that drug

use of this sort is a profound problem. As health researchers, we need to argue forcefully that there are entirely preventable causes lying behind many compulsive drug problems and to work towards finding *political* solutions—in addition to providing resources for people who have suffered in this way to talk and be heard. It is no coincidence that problematic drug use flourishes in traumatic environments like C's, nor that should it be surprising that drug abuse has increased to its current scale at precisely the same point as neoliberalism has rendered life unliveable for so many people.

On the other hand, there is no obvious political solution that would cure E's addiction or would have prevented it in the first place. Much can be said, of course, about the value of providing support to troubled families and safeguarding vulnerable children, and more must be done to reduce the amount of time that offenders like E spend in prisons and to stop the violence that is endemic there. Nevertheless, E's addiction will not be healed by political changes alone. The way that he discussed his life history was complex, often contradictory, and required interpretation. Drug problems like these require time and space for people to speak and have themselves heard by someone who cares for them. E's case then, suggests a need for interpretation and clinical intervention, while C's requires, first and foremost, material changes in the subject's environment.

The goal of this article is to contribute to deeper understandings of addiction as a social and spatial phenomenon and to assist researchers in thinking about how addicted people can be helped. The experience of compulsion that we call addiction has always named a variety of different experiences, born of circumstances and situations particular to each drug user. As critical health researchers, it is essential that we make space for ways of understanding addiction that accommodate the diversity of people's relationships to drugs, addiction, recovery, and their own traumatic landscapes.

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Traumatic landscapes: Two geographies of addiction
Jesse Proudfoot, Durham University

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Highlights

- Case histories illustrate the ways that socio-political forces produce addictions
- “Addictogenic landscapes” are environments that traumatize and encourage addiction
- “Landscapes of trauma” describe personal geographies of addiction, trauma, and place
- Addictions can be understood as self-medication and as symptoms of the unconscious
- Treatment should focus on the traumas and oppressive forces that produce addiction